STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
LIMITATIONS ON AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED TO MEDICALLY NEEDY GROUPS
PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND OR DISABLED

Prior authorization is required when the number of prescriptions exceeds a State-specified amount in a calendar month. The State-specified amount of prescriptions does not include prescriptions for emergencies, in which case a 72-hour supply, or up to a six (6) day supply, may be dispensed before obtaining prior approval. Prior authorization is not required for pharmaceutical services to a resident in a nursing facility or in an assisted living residence, comprehensive personal care home or residential health care facility, or for prescriptions for clozapine, antihemophiliac drugs, immunosuppressants, and HIV/AIDS drugs (limited to protease inhibitors, antiretroviral drugs, nucleoside analogs and reverse transcriptase inhibitors).

The least expensive, therapeutically effective protein nutritional supplements or specialized infant formulas shall be dispensed if the prescriber has not indicated "brand medically necessary" on the prescription.

Reimbursement is not available for unit-dose packaged drug products dispensed to residents in a boarding home, residential care setting, or other community-type setting. Other community-type settings shall not include certain assisted living settings, including assisted living residences (ALRs), comprehensive personal care homes (CPCHs), and alternative family care (AFC) homes licensed by the Department of Health and Senior Services. Drug products which are commercially available only as a unit-dose product are covered when not otherwise marketed as a chemically equivalent product.

Medical services, medical procedures or prescription drugs whose use is to promote or enhance fertility are not a covered service.

For claims with service dates on or after July 1, 1998, all impotency drugs shall be limited to male beneficiaries over the age of 18 years and shall be limited to four (4) treatments per month.

For claims with service dates on or after July 1, 1998, prescribers must write "Diagnosis of Impotence" on the face of any prescription for impotency drugs. If that statement has not been written by the prescriber on the face of the prescription, payment for the impotency drug shall be subject to recoupment by the State of New Jersey.

Prescribed drugs are available only to pregnant women and dependent children.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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12(a) "Bundled drug service" means a covered outpatient drug for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

(a) Any bundled drug service shall not be eligible for reimbursement by the New Jersey Medicaid Program.

1. This provision may be waived at the discretion of the Commissioner if he or she determines that a bundled drug service is less than or equal to the total cost of the unbundled components if reimbursed separately; or

2. The Commissioner may waive the provisions for reasons of medical necessity for a bundled drug or in accordance with terms approved by the Department as follows:

i. Those instances where discontinuation, withdrawal, or elimination of the use of the bundled drug in someone who has been receiving the bundled drug would result in deprivation of life saving or life prolonging benefits of the drug or would cause potential harm or serious exacerbation of the illness being treated; or

ii. Those instances where use of the bundled drug has resulted in or produced marked improvement in the recipient's clinical status reflected in alleviation of symptoms, and elevation of level of function and independence.

iii. In order to determine eligibility for reimbursement, manufacturers or distributors of a bundled drug service shall submit complete product information, including the cost to the Program of the total bundled drug service, discrete costs of each component of the bundled drug service, cost benefit analyses, and other information as requested by the Department, to the Chief Pharmaceutical Consultant, Division of Medical Assistance and Health Services, CN- 712, Trenton, New Jersey 08625-0712.

iv. If the Commissioner determines that a bundled drug is eligible for reimbursement, New Jersey Medicaid recipients shall be eligible for the bundled drug service if prior authorization is requested and approved. Prior authorization shall be obtained by completing the appropriate "Request for Authorization Form" requesting medication management authorization and providing sufficient documentation to establish that it is medically necessary to continue the bundled drug services.

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12(b) **Dentures:**

Prior authorization is required for partial or complete dentures, which are provided only when masticatory deficiencies are likely to impair the general health of the patient.

Dentures are provided only once in each arch during a seven and one half year period. Exceptions may be made for extenuating circumstances which must be documented.

These services are available to all three coverage groups (pregnant women, dependent children, and the aged, blind or disabled).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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12(c) Prosthetic and Orthotic Appliances:

For purposes of the New Jersey Medicaid program policies, "an orthopedic shoe" is defined as "orthopedic footwear" or "footwear", with or without accompanying appliances, used to prevent or correct gross deformities of the feet.

Prosthetic and Orthotic services are provided with the following limitations:

1) Orthopedic footwear and foot orthotics require prior authorization.

2) Orthopedic footwear is provided: (a) when attached to a brace or bar; (b) when part of a post-operative or post-fracture treatment plan or (c) when used to correct or adapt to gross foot deformities.

3) Prior authorization is required for prostheses, i.e., limbs, when the provider's customary charge exceeds $1000., and for orthotic devices, i.e., braces and supports, when the provider's customary charge exceeds $500.

4) Prior authorization is required for replacement parts when the provider's customary charge exceeds $250.

5) Prior authorization is required for labor, as distinct from replacement parts, when the provider's customary charge exceeds $250.

6) Travel reimbursement policy: Travel is reimbursable only when the distance is greater than 5 miles one way. If more than one recipient is seen during the visit, travel allowance may only be billed for the initial recipient.

These services are available to all three coverage groups (pregnant women, dependent children, and the aged, blind or disabled).

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12(d) **Eyeglasses:**

When optical appliances are requested more than once every two years for persons 19 through 59 years of age or more frequently than once a year for persons less than 19 years or over 60 years, prior authorization will be required unless there is a substantial prescription change, the optical appliance is lost or stolen with documentation available.

Provided with the following limitations: 1) Prescription sunglasses not provided; 2) Bifocals only when prescribed; 3) Tinted lens only when medically indicated, and 4) Contact lenses only for specific ocular pathological conditions or for patient who cannot be fitted with regular lenses.

Prior authorization is required for:

- Low vision devices with a charge exceeding a minimum established by the Division.
- Selected optical tests;
- Vision training devices;
- Repair of or replacement of an optical appliance when the charge exceeds a Division established minimum;
- High index lenses;
- Special base curve lenses;
- All other optical appliances which require additional charges.

Ophthalmologists, optometrists and opticians are permitted to dispense eyeglasses.

Prior authorization is required for the replacement of an optical appliance except in extenuating circumstances, such as a substantial prescription change, the optical appliance is lost or stolen with documentation available.

These services are available to all three coverage groups (pregnant women, dependent children, and the aged, blind or disabled).

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13(a) **Diagnostic Services:**

Diagnostic services are provided to all three coverage groups (pregnant women, dependent children and the aged, blind and disabled).

Diagnostic services are limited to non-experimental procedures.

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13(b) **Screening Services:**

Provided, with no limitations.

Screening services are provided for all three coverage groups (pregnant women, dependent children and the aged, blind or disabled).

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13(c) **Preventive Services:**

HealthStart Health Support preventive services are limited to pregnant women. HealthStart services are available to all three coverage groups (pregnant women, and dependent children or the aged, blind or disabled who may also be pregnant).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Limitations on Amount, Duration and Scope of Services

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13(d) Rehabilitative Services:

1. Rehabilitative services, except for lead inspection services, require prior authorization.

2. Environmental lead inspection services are limited to Local Health Departments when the services are performed by certified lead inspectors/assessors; when the services are provided in the primary residences of Medicaid beneficiaries who are children identified as having elevated blood lead levels; and when these children are referred to the LHDs by the New Jersey State Department of Health.

3. Rehabilitative services are avaiable to all three eligibility groups (pregnant women, dependent children and the aged, blind and disabled.)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Limitations on Amount, Duration and Scope of Services
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PREGNANT WOMEN, DEPENDENT CHILDREN, AND THE AGED, BLIND, OR DISABLED

Institutions for Mental Diseases, for Persons Age 65 or Older:

Services for Institutionalized Persons Age 65 or Older:

14(a) Inpatient Hospital Services:

Not provided.

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